

19 December 2025

Private and Confidential

Mr Sean Horstead
HM Area Coroner
Coroner's Court
Seax House
Victoria Road South
Chelmsford
CM1 1QH

Chief Executive Office
The Lodge
Lodge Approach
Wickford
Essex
SS11 7XX

Dear Sir,

Mr Stephen John Neville (RIP)

I write to set out the Trust's formal response to the report made under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, dated 24th October 2025 in respect of the above, issued to the Trust following the inquest into the sad death of Mr Neville.

I would like to begin by extending my deepest condolences to Mr Neville's family. The Trust sympathises with their sad loss.

The matters of concern as noted within the Regulation 28 Report have been carefully reviewed and noted. I will now respond in full to these concerns in the hope that this provides both yourself and Mr Neville's family with comprehensive assurance of changes that have been made at the Trust to address the concerns you have raised.

Concern 1) There was a failure on the part of EPUT nursing and (particularly) support staff to appropriately *undertake and record* the required therapeutic engagement and interaction observations. Members of support staff demonstrably misunderstood (and appear to still misunderstand) the nature and purpose of Level 2 'intermittent' (4 to 5 times) hourly observations, apparently routinely conducting such observations every 15 minutes on the hour, the quarter past and so on. Whilst the observations, when made, recorded the location of the patient and (very occasionally) noted what the patient may be doing, nothing was recorded in respect of an interaction or therapeutic engagement, as required by Trust policy. Such a lack of understanding of the basic role of the support worker and/or nursing staff in undertaking such critically important roles disclosed an (on-going) deficit in training.

Response:

In line with the details set out in the Trust's learning statement filed with the Court, with respect to the Trust's approach to Observation and Engagement, the Trust continues to shift focus to Therapeutic engagement rather than observation alone. This aligns with the national working group the Trust participated in across 2024 and led to the development of the Mental Health / Learning Disability Nurse Director guidance document.

This is supported by the Trust Therapeutic engagement and Observation clinical guideline and training material which provides guidance on Therapeutic engagement and observation with our patients.

At this Inquest it was evident that one Health Care Assistant (HCA) did not understand the requirements of level 2 observation in relation to the random nature of level 2 observations. It is of that that they had been absent from work for a period of 9 months before the inquest. The Ward Manager is working with this staff member to re-undertake Observation and Engagement Competencies.

The Ward Manager has also undertaken a check of all staff Observation and Engagement competencies to ensure confidence in current staff practice. As part of this process the Ward Manager checked that all staff have completed Oxevision E-Observation training, which includes training on documenting on e-observations to ensure therapeutic engagement is captured. This ensures a focus on the quality of the therapeutic engagement and observation.

To further enhance Trust routine online training, the Ward Manager is providing a number of focused face to face training sessions with ward staff to further gain assurance around interpretation and understanding. This will include highlighting the importance of recording therapeutic engagement and space for reflection on learning. This is due to be completed by the end of December 2025.

As part of the Trustwide learning response, the learning from this inquest has been shared through the care unit quality and safety meeting to ensure shared learning across the wider care unit. This has also been shared with the Training team with a specific focus on Oxevision e-observation training to ensure this training robustly guides staff on engagement techniques and importance of the quality of recording of the engagement. This training was reviewed in February 2025 following the Trust's recent review of the Oxevision SOP.

The trust recognises it is important that it continually reviews and evolves all training and staff support programmes and this is undertaken by the Training Team with relevant experts, taking into account new guidance and learning.

Finally, it is noted that the e-observations box on the electronic form is the same box wherein engagement would also be documented and is not a mandatory field. A request has been made to Oxehealth asking for this to be mandated box for all observations levels 2, 3 and 4. Oxehealth have confirmed this is achievable and this change is in progress.

Concern 2) Further, the clear evidence also disclosed an *on-going* failure in the quality assurance and auditing processes deployed by EPUT. A purported weekly quality assurance check being undertaken by the Ward Manager in December 2021, which claimed "*an audit score of 100%*", was entirely at odds with the evidence at inquest which revealed repeated and significant inadequacies in the nature and quality of the observations undertaken and recorded.

Response:

Reflection has been undertaken on this learning point with key staff including the current Ward Manager and Matron. Staff reflected that audits should be transparent and agreed that it was good practice to acknowledge gaps and take appropriate action in a timely manner. Staff expressed that they would be confident in presenting audits where the findings show gaps and gave recent examples of action taken following audits. The Matron is continuing to work with staff on the importance of accurate audit results and accountability. The matron is also conducting spot checks on audits that consistently report high level compliance as an additional assurance measure.

From a Trust wide learning perspective, a review is already underway of the Trust Tenable audit programme. The current Trust Tenable audit programme has been in place for 12 months and this review was already in progress prior to the inquest. This work will be co-

produced with all ward matrons to ensure full engagement with the audit process and senior leadership supporting open and transparent completion.

The Trust has since strengthened the reporting of results from audits; with results discussed at the monthly care unit Quality & Safety Meetings and this is supported by the implementation of a Quality & Safety dashboard utilising Power BI (Power BI is a business intelligence tool developed by Microsoft that transforms raw data into visual insights allowing organisations to make data-driven decisions). The dashboard provides the Trust with a range of information, from an overall perspective of results as an organisation.

The Tendable platform is available for all ward managers, matrons, operational managers and senior managers allowing them easy access to results through a digital app or web based platform. Reports/results are available via the Tendable platform for ward and team discussions and for learning to take place.

Concern 3) Of even greater concern is that even after the move from paper to electronic observation records the same Beech Ward Manager (then and now) stated in evidence: *“I have no audit tool I am not confident that the audits are accurate and complete now ... there is no audit process in place to check the quality of observation and engagement documentation.”*

Response:

In October 2024, EPUT launched a new Quality Assurance Audit Programme across all inpatient areas. This initiative was driven by feedback highlighting issues with previous paper-based audits, including repetitive and duplicated questions across Tendable audits and other checks conducted outside the platform. There was also inconsistency in understanding who should complete audits and when. Ward Managers and Matrons reported limited visibility of audit results and minimal use of findings for quality improvement.

To address these concerns, a project team of senior nurses and audit specialists reviewed all existing Tendable question sets and external audit checklists. Duplicate and outdated questions were removed, and relevant items from daily, weekly, and monthly ward audits were consolidated into the new Tendable framework. As part of this process, dedicated observation audits were discontinued, and observation-related questions were integrated into the Ward Managers' audit within Tendable.

Building on this review, further enhancements were introduced following inquest-related reflections. In November 2025, three new Oxevision audits were implemented to strengthen oversight of observation and therapeutic engagement, incorporating both staff and patient feedback:

- **Matrons Oxevision Consent Audit**
- **Matrons Oxevision Staff Training Audit**
- **Oxevision Policy & Governance Audit**

The Oxevision Training Audit, conducted fortnightly, involves direct staff engagement to assess understanding of Oxehealth processes, observations, and therapeutic engagement. Any knowledge gaps identified are addressed through one-to-one sessions. Results are reported fortnightly to the Executive Team and shared at Care Unit Quality & Safety meetings, where Matrons monitor compliance and implement corrective actions.

Monthly reports provide two key metrics:

- **Compliance Score** – how well wards performed on each audit
- **Completion Score** – the percentage of scheduled audits completed and submitted

These reports are distributed to wards and care units, with bespoke reports issued to address local issues and ensure adherence to audit schedules.

Concern 4) The Deputy Director of Quality and Safety (Inpatient and Urgent Care) recognised in her written and oral evidence that the available free text box now included on the electronic version of the records relating to observation and engagement is *“not a mandatory field”* in the recording process and that: *“it appears that at some point the Tendable audits were amended to omit the audits of the quality and nature of the observation records.”*

Response:

Please see response to concern 1 above. Again, currently the e-observations form part of the text field, where engagement would be documented and is not a mandatory field. A request has been made to Oxehealth asking for this to be clarified and mandated for all observations levels 2,3 and 4, which will in turn assist in respect of audit and review.

Concern 5) It remains unclear how (or why) this came about, and I am very concerned that the apparent reliance on staff supervision (as per paragraph 7.1 of the *Therapeutic Engagement and Supportive Observation Clinical Guideline (Inpatients)*) and staff handovers to rigorously audit the nature and quality of the conduct and recording of therapeutic engagement and supportive observations remains a wholly inadequate mechanism for the purposes of achieving appropriate qualitative compliance monitoring.

Response:

Please see responses above (concern 2 and 3) which outline the Tendable audit programme process.

We have also reviewed the audit templates within our tenable system to ensure the quality of this process is now reviewed as part of the trust wider audit assurance process, this alongside making the commentary box within observation recording a mandatory field has considerably strengthened our trust assurance on this matter.

Concern 6) The lacuna identified above gives rise to a real concern regarding the robustness of EPUT quality assurance and auditing processes generally, and particularly in the context of the on-going issues relating to the nature and quality of the conduct by EPUT staff of such critically important observations including the essential therapeutic engagements and interactions, with highly vulnerable inpatients at risk of suicide. This is a concern, I am told, also shared by the Deputy Director quoted above.

Response:

Please see responses above (concern 2 and 3) which outline the Tendable audit programme process.

As part of the review of the Tendable audit programme a session will be held with all matrons to review the Tendable audit programme and process to seek to understand from them what changes are needed to meet the needs of their teams. The process will also consider learning from over the last 12 months, including PFD learning to ensure an appropriate quality assurance audit programme is set. This review will also be an opportunity to strengthen governance processes for reporting ward to board. It is anticipated this review will be completed over the next 6 months.

In addition as set out in concern 6, immediate changes have been made as an interim measure pending the longer term review.

I hope that I have provided reassurances around the steps that we have taken to address the issues of concern contained within your report. We know there is an acute need to embed and effect change, hence we will monitor the above provisions to ensure these are contributing to our overall aim of keeping patents safe and delivering therapeutic care.

Please do let me know if you require any further information at this stage. We understand that the Court will share a copy of this reply with Mr Neville's family.

Yours sincerely

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Chief Executive